Senate Bill No. 375

CHAPTER 206

An act to amend Sections 1358.4, 1358.5, 1358.6, 1358.8, 1358.9, 1358.10, 1358.11, 1358.14, 1358.15, 1358.16, 1358.17, 1358.18, 1358.20, and 1358.21 of, and to repeal and add Section 1358.12 of, the Health and Safety Code, and to amend Sections 10192.4, 10192.5, 10192.6, 10192.8, 10192.9, 10192.10, 10192.11, 10192.14, 10192.15, 10192.17, 10192.18, 10192.20, and 10192.21 of, and to repeal and add Section 10192.12 of, the Insurance Code, relating to health care coverage.

[Approved by Governor September 6, 2005. Filed with Secretary of State September 6, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 375, Speier. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance. Under existing law, a plan or insurer that issues a Medicare supplement contract or policy, as defined, is required to comply with requirements in addition to those generally imposed on health care service plan contracts and health insurance policies.

This bill would make certain changes to these Medicare supplement coverage provisions corresponding to revisions made to the Medicare program by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The bill would revise eligibility requirements for Medicare supplement coverage, including the guaranteed issue of coverage, and would add 2 benefit plans. The bill would also revise application procedures for this coverage.

Because a violation of the new requirements for Medicare supplement coverage issued by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1358.4 of the Health and Safety Code is amended to read:

1358.4. The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) An individual enrollee who seeks to contract for health coverage, in the case of an individual Medicare supplement contract.

(2) An enrollee who seeks to obtain health coverage through a group, in the case of a group Medicare supplement contract.

(b) "Bankruptcy" means that situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(c) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(d) (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) Any individual or group contract, policy, certificate, or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage.

(B) Part A or B of Title XVIII of the federal Social Security Act (Medicare).

(C) Title XIX of the federal Social Security Act (medicaid), other than coverage consisting solely of benefits under Section 1928 of that act.

(D) Chapter 55 of Title 10 of the United States Code (CHAMPUS).

(E) A medical care program of the Indian Health Service or of a tribal organization.

(F) A state health benefits risk pool.

(G) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(I) A health benefit plan under Section 5(e) of the federal Peace Corps Act (Section 2504(e) of Title 22 of the United States Code).

(J) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(K) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(A) Coverage for accident-only or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if offered as a separate policy, certificate, or contract:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(e) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) "Insolvency" means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(g) "Issuer" means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include

entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.

(h) "Medicare" means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(i) "Medicare Advantage Plan" means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(j) "Medicare supplement contract" means a group or individual plan contract of hospital and medical service associations or health care service plans, other than a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C.A. Section 1395mm) or an issued contract under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Contract" means "Medicare supplement contract," unless the context requires otherwise. "Medicare supplement contract" does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.

(k) "Secretary" means the Secretary of the United States Department of Health and Human Services.

SEC. 2. Section 1358.5 of the Health and Safety Code is amended to read:

1358.5. (a) A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless the contract contains definitions or terms that conform to the requirements of this section.

(1) (A) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or other similar words of description or characterization.

(B) The definition shall not be more restrictive than the following: "injury or injuries for which benefits are provided means accidental bodily injury sustained by the covered person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while coverage is in force."

(C) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers'

compensation, employer's liability, or similar law, unless prohibited by law.

(2) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

(3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

(4) "Health care expenses" means for purposes of Section 1358.14, expenses of health care service plans associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

(6) "Medicare" shall be defined in the contract. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended," or "Title I, Part I of Public Law 89-97, as enacted by the 89th Congress and popularly known as the Health Insurance for the Aged Act, as amended," or words of similar import.

(7) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(8) "Physician" shall not be defined more restrictively than as defined in the Medicare Program.

(9) (A) "Sickness" shall not be defined more restrictively than as follows: "sickness means illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force."

(B) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(b) Nothing in this section shall be construed as prohibiting any contract, by definitions or express provisions, from limiting or restricting any or all of the benefits provided under the contract, except in-area and out-of-area emergency services, to those health care services that are delivered by issuer, employed, owned, or contracting providers, and provider facilities, so long as the contract complies with the provisions of Sections 1358.14 and 1367 and with Section 1300.67 of Title 28 of the California Code of Regulations.

(c) Nothing in this section shall be construed as prohibiting any contract that limits or restricts any or all of the benefits provided under the contract in the manner contemplated in subdivision (b) from limiting its obligation to deliver services, and disclaiming any liability from any delay or failure to provide those services (1) in the event of a major disaster or epidemic or (2) in the event of circumstances not reasonably within the control of the issuer, such as the partial or total destruction of facilities, war, riot, civil

insurrection, disability of a significant part of its health personnel, or similar circumstances so long as the provisions comply with the provisions of subdivision (h) of Section 1367.

SEC. 3. Section 1358.6 of the Health and Safety Code is amended to read:

1358.6. (a) (1) Except for permitted preexisting condition clauses as described in Sections 1358.7 and 1358.8, a contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract if the contract contains definitions, limitations, exclusions, conditions, reductions, or other provisions that are more restrictive or limiting than that term as officially used in Medicare, except as expressly authorized by this article.

(2) No issuer may advertise, solicit, or issue for delivery any Medicare supplement contract with hospital or medical coverage if the contract contains any of the prohibited provisions described in subdivision (b).

(b) The following provisions shall be deemed to be unfair, unreasonable, and inconsistent with the objectives of this chapter and shall not be contained in any Medicare supplement contract:

(1) Any waiver, exclusion, limitation, or reduction based on or relating to a preexisting disease or physical condition, unless that waiver, exclusion, limitation, or reduction (A) applies only to coverage for specified services rendered not more than six months from the effective date of coverage, (B) is based on or relates only to a preexisting disease or physical condition defined no more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage, (C) does not apply to any coverage under any group contract, and (D) is approved in advance by the director. Any limitations with respect to a preexisting condition shall appear as a separate paragraph of the contract and be labeled "Preexisting Condition Limitations."

(2) Except with respect to a group contract subject to, and in compliance with, Section 1399.62, any provision denying coverage, after termination of the contract, for services provided continuously beginning while the contract was in effect, during the continuous total disability of the subscriber or enrollee, except that the coverage may be limited to a reasonable period of time not less than the duration of the contract benefit period, if any, and may be limited to the maximum benefits provided under the contract.

(c) A Medicare supplement contract in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 1358.8, a Medicare supplement contract with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current enrollees and subscribers, at their option, who do not enroll in Medicare Part D.

(2) A Medicare supplement contract with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement contract with benefits for outpatient prescription drugs shall not be renewed after the enrollee or subscriber enrolls in Medicare Part D unless both of the following conditions exist:

(A) The contract is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred after the effective date of the individual's coverage under a Medicare Part D plan.

(B) The premium is adjusted to reflect the elimination of outpatient prescription drug coverage at the time of enrollment in Medicare Part D, accounting for any claims paid if applicable.

SEC. 4. Section 1358.8 of the Health and Safety Code is amended to read:

1358.8. The following standards are applicable to all Medicare supplement contracts advertised, solicited, or issued for delivery on or after January 1, 2001. A contract shall not be advertised, solicited, or issued for delivery as a Medicare supplement contract unless it complies with these benefit standards.

(a) The following general standards apply to Medicare supplement contracts and are in addition to all other requirements of this article:

(1) A Medicare supplement contract shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The contract shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement contract shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement contract shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Prepaid or periodic charges may be modified to correspond with those changes.

(4) A Medicare supplement contract shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the covered person, other than the nonpayment of the prepaid or periodic charge.

(5) Each Medicare supplement contract shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the contract solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the contract for any reason other than nonpayment of the prepaid or periodic charge or misrepresentation of the risk by the applicant that is shown by the plan to be material to the acceptance for coverage. The contestability period for Medicare supplement contracts shall be two years.

(C) If a group Medicare supplement contract is terminated by the subscriber and is not replaced as provided under subparagraph (E), the issuer shall offer enrollees an individual Medicare supplement contract that, at the option of the enrollee, either provides for continuation of the benefits contained in the terminated contract or provides for benefits that otherwise meet the requirements of this subsection.

(D) If an individual is an enrollee in a group Medicare supplement contract and the individual membership in the group is terminated, the issuer shall either offer the enrollee the conversion opportunity described in subparagraph (C) or, at the option of the subscriber, shall offer the enrollee continuation of coverage under the group contract.

(E) If a group Medicare supplement contract is replaced by another group Medicare supplement contract purchased by the same subscriber, the issuer of the replacement contract shall offer coverage to all persons covered under the old group contract on its date of termination. Coverage under the new contract shall not result in any exclusion for preexisting conditions that would have been covered under the group contract being replaced.

(F) If a Medicare supplement contract eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), the contract as modified as a result of that act shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement contract shall be without prejudice to any continuous loss that commenced while the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the covered person, limited to the duration of the contract benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) (A) (i) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the enrollee for the period, not to exceed 24 months, in which the enrollee has applied for and is determined to be entitled to medical assistance under Title XIX of the federal Social Security Act, but only if the enrollee notifies the issuer of the contract within 90 days after the date the individual becomes entitled to assistance.

If suspension occurs and if the enrollee loses entitlement to medical assistance, the contract shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the enrollee provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement.

(ii) A Medicare supplement contract shall provide that benefits and premiums under the contract shall be suspended at the request of the

enrollee or subscriber for any period that may be provided by federal regulation if the enrollee or subscriber is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and the enrollee or subscriber loses coverage under the group health plan, the contract shall be automatically reinstituted, effective as of the date of loss of coverage if the enrollee or subscriber provides notice within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement contract provided coverage for outpatient prescription drugs, reinstitution of the contract for a Medicare Part D enrollee shall not include coverage for outpatient prescription drugs but shall otherwise provide coverage that is substantially equivalent to the coverage in effect before the date of suspension.

(iii) Shall provide for classification of prepaid or periodic charges on terms at least as favorable to the enrollee as the prepaid or periodic charge classification terms that would have applied to the enrollee had the coverage not been suspended.

(8) A Medicare supplement contract shall not be limited to coverage for a single disease or affliction.

(9) A Medicare supplement contract shall provide an examination period of 30 days after the receipt of the contract by the applicant for purposes of review, during which time the applicant may return the contract as described in subdivision (e) of Section 1358.17.

(10) A Medicare supplement contract shall additionally meet any other minimum benefit standards as established by the director.

(11) Within 30 days prior to the effective date of any Medicare benefit changes, an issuer shall file with the director, and notify its subscribers and enrollees of, modifications it has made to Medicare supplement contracts.

(A) The notice shall include a description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(B) The notice shall inform each subscriber and enrollee as to when any adjustment in the prepaid or periodic charges will be made due to changes in Medicare benefits.

(C) The notice of benefit modifications and any adjustments to the prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension. The notice shall not contain or be accompanied by any solicitation.

(12) No modifications to existing Medicare supplement coverage shall be made at the time of, or in connection with, the notice requirements of this article except to the extent necessary to eliminate duplication of

Medicare benefits and any modifications necessary under the contract to provide indexed benefit adjustment.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a contract including only the following basic "core" package of benefits to each prospective applicant. This "core" package of benefits shall be referred to as standardized Medicare supplement benefit plan "A". An issuer may make available to prospective applicants any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the enrollee or subscriber for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 1358.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) With respect to the Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) With respect to 80 percent of the Medicare Part B excess charges, coverage for 80 percent of the difference between the actual Medicare Part

B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge.

(5) With respect to 100 percent of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge.

(6) With respect to the basic outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two-hundred-fifty-dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement contract may be sold or issued if it includes a prescription drug benefit.

(7) With respect to the extended outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two-hundred-fifty-dollar ($250) calendar year deductible, to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement contract may be sold or issued if it includes a prescription drug benefit.

(8) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) With respect to the preventive medical care benefit, coverage for the following preventive health services:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

(B) The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which are determined to be medically appropriate by the attending physician:

(i) Fecal occult blood test.

(ii) Mammogram.

(C) Influenza vaccine administered at any appropriate time during the year.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMACPT) codes, to a maximum of one hundred

twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) With respect to the at-home recovery benefit, coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, or a personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without any limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

(ii) The covered person's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the covered person's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

(III) One thousand six hundred dollars ($1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the covered person is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the covered person is receiving Medicare-approved home care services or no more

than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment for this benefit as payment in full and shall not bill the enrollee or subscriber for any balance.

(4) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.

(5) With respect to skilled nursing facility care, coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (10) is met.

(6) With respect to hospice care, coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (10) is met.

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (10) is met.

(8) Except for coverage provided in paragraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible, until the out-of-pocket limitation is met as described in paragraph (10).

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services, after the enrollee or subscriber pays the Medicare Part B deductible.

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(e) The standardized Medicare supplement benefit plan "L" shall consist of the following benefits:

(1) The benefits described in paragraphs (1), (2), (3), and (9) of subdivision (d).

(2) With respect to the Medicare Part A deductible, coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (8) is met.

(3) With respect to skilled nursing facility care, coverage for 75 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.

(4) With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.

(5) Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the enrollee or subscriber pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars ($2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) A contract shall not contain any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the issuer of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

SEC. 5. Section 1358.9 of the Health and Safety Code is amended to read:

1358.9. (a) An issuer shall make available to each prospective enrollee a contract form containing only the basic (core) benefits, as defined in subdivision (b) of Section 1358.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by subdivision (f) and by Section 1358.10.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to J, inclusive, listed in subdivision (e), and shall conform to the definitions in Section 1358.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b), (c), (d), and (e) of Section 1358.8 and list the benefits in the order listed in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subdivision (c), other designations to the extent permitted by law.

(e) With respect to the makeup of benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall be limited to the basic (core) benefit common to all benefit plans, as defined in subdivision (b) of Section 1358.8.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the core benefit, plus the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 1358.8.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), and (8) of subdivision (c) of Section 1358.8, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (8), and (10) of subdivision (c) of Section 1358.8, respectively.

(5) Standardized Medicare supplement benefit plan E shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of Section 1358.8, respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: the core benefit, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary

emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(8) Standardized Medicare supplement benefit plan G shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (4), (8), and (10) of Section 1358.8, respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (6), and (8) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in

paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 1358.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement contract sold on or after January 1, 2006.

(13) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in subdivision (d) of Section 1358.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 1358.8.

(f) An issuer may, with the prior approval of the director, offer contracts with new or innovative benefits in addition to the benefits provided in a contract that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement contracts, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement contracts. On and after January 1, 2006, the innovative benefit shall not include an outpatient prescription drug benefit.

SEC. 6. Section 1358.10 of the Health and Safety Code is amended to read:

1358.10. (a) (1) This section shall apply to Medicare Select contracts, as defined in this section.

(2) A contract shall not be advertised as a Medicare Select contract unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) “Grievance” means dissatisfaction expressed in writing by an individual covered by a Medicare Select contract with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) “Medicare Select issuer” means an issuer offering, or seeking to offer, a Medicare Select contract.

(4) “Medicare Select contract” means a Medicare supplement contract that contains restricted network provisions.

(5) “Network provider” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select contract. “Provider network” means a grouping of network providers.

(6) “Restricted network provision” means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) “Service area” means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select contract.

(c) The director may authorize an issuer to offer a Medicare Select contract pursuant to Section 4358 of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer’s Medicare Select contracts are in compliance with this chapter and if the director finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare Select issuer shall not issue a Medicare Select contract in this state until its plan of operation has been approved by the director.

(e) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

(A) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and afterhour care. The hours of operation and availability of afterhour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) That the number of network providers in the service area is sufficient, with respect to current and expected enrollees, as to either of the following:

(i) To deliver adequately all services that are subject to a restricted network provision.

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 24 hours per day and seven days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, that there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual covered under a Medicare Select contract.

This subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select contract.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including all of the following:

(A) The formal organizational structure.

(B) The written criteria for selection, retention, and removal of network providers.

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subdivision (i).

(7) Any other information requested by the director.

(f) (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

(g) A Medicare Select contract shall not restrict payment for covered services provided by nonnetwork providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition.

(2) It is not reasonable to obtain services through a network provider.

(h) A Medicare Select contract shall provide payment for full coverage under the contract for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select contract to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and charges of the Medicare Select contract with both of the following:

(A) Other Medicare supplement contracts offered by the issuer.

(B) Other Medicare Select contracts.

(2) A description, including address, telephone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. The description shall inform the applicant that expenses incurred when using out-of-network providers are excluded from the out-of-pocket annual limit in benefit plans K and L, unless the contract provides otherwise.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the enrollee's rights to purchase any other Medicare supplement contract otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(j) Prior to the sale of a Medicare Select contract, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subdivision (i) and that the applicant understands the restrictions of the Medicare Select contract.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the enrollees. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the contract and in the outline of coverage.

(2) At the time the contract is issued, the issuer shall provide detailed information to the enrollee describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(*l*) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select contract the opportunity to purchase any Medicare supplement contract otherwise offered by the issuer.

(m) (1) At the request of an enrollee under a Medicare Select contract, a Medicare Select issuer shall make available to the enrollee the opportunity to purchase a Medicare supplement contract offered by the

issuer that has comparable or lesser benefits and that does not contain a restricted network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(n) Medicare Select contracts shall provide for continuation of coverage in the event the secretary determines that Medicare Select contracts issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each enrollee covered by a Medicare Select contract the opportunity to purchase any Medicare supplement contract offered by the issuer that has comparable or lesser benefits and that does not contain a restricted provider network provision, if a Medicare supplement contract of that nature is offered by the issuer. The issuer shall make the contracts available without regard to the health status of the enrollee and without requiring evidence of insurability after the Medicare Select contract has been in force for six months.

(2) For the purposes of this subdivision, a Medicare supplement contract will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select contract being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(o) An issuer offering Medicare Select contracts shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program. An issuer shall not issue a Medicare Select contract in this state until the contract has been approved by the director.

SEC. 7. Section 1358.11 of the Health and Safety Code is amended to read:

1358.11. (a) (1) An issuer shall not deny or condition the offering or effectiveness of any Medicare supplement contract available for sale in this state, nor discriminate in the pricing of a contract because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a contract that is submitted prior

to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement contract currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants, Medicare supplement benefit plan H, I, or J, if currently available, and commencing January 1, 2007, shall make available to them Medicare supplement benefit plan K or L, if currently available. The selection among Medicare supplement benefit plan H, I, or J and the selection between Medicare supplement benefit plan K or L shall be made at the issuer's discretion.

(3) This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.

(c) Except as provided in subdivision (b) and Section 1358.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Sales during the open enrollment period shall not be discouraged by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included covered persons.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the issuer.

(g) (1) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any and all Medicare supplement coverage available on a guaranteed basis under state and federal law or regulations for persons terminated by their Medicare Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(i) Commencing January 1, 2007, an individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program because of an increase in the individual's income or assets.

SEC. 8. Section 1358.12 of the Health and Safety Code is repealed.

SEC. 9. Section 1358.12 is added to the Health and Safety Code, to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who seek to enroll under the contract during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement contract described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement contract because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement contract.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently

furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement contract issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(F) The individual meets other exceptional conditions as the secretary may provide.

(3) The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) The individual is enrolled under a Medicare supplement contract, and the enrollment ceases because of any of the following circumstances:

(A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the contract.

(B) The issuer of the contract substantially violated a material provision of the contract.

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(7) The individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) The individual while enrolled under a Medicare supplement contract that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement contract, and submits evidence of enrollment in Medicare Part D along with the application for a contract described in paragraph (4) of subdivision (e).

(c) (1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminated:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subparagraph (A) of paragraph (5) of subdivision (b), the guaranteed issue period begins on the earlier of the following two dates and ends on the date that is 63 days after the date the coverage is terminated:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any.

(B) The date that the applicable coverage is terminated.

(4) In the case of an individual described in paragraph (2), (3), (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of, subdivision (b) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement contract with an outpatient prescription drug benefit, is entitled to a Medicare supplement contract that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement contract offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement contract with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or contract, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy or contract, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement contracts under subdivision (a). The notice shall be communicated within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an enrollee or subscriber paid in advance and shall terminate coverage upon the request of an enrollee or subscriber.

SEC. 10. Section 1358.14 of the Health and Safety Code is amended to read:

1358.14. (a) (1) (A) With respect to loss ratio standards, a Medicare supplement contract shall not be advertised, solicited, or issued for delivery unless the contract can be expected, as estimated for the entire

period for which prepaid or periodic charges are computed to provide coverage, to return to subscribers and enrollees in the form of aggregate benefits under the contract, not including anticipated refunds or credits provided under the contract, at least 75 percent of the aggregate amount of charges earned in the case of group contracts, or at least 65 percent of the aggregate amount of charges earned in the case of individual contracts, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices.

(B) Loss ratio standards shall be calculated on the basis of incurred health care expenses where coverage is provided by a health care service plan on a service rather than reimbursement basis, and earned prepaid or periodic charges shall be calculated for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care service plan shall not include any of the following:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to prepaid or periodic charges comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision (d) of Section 1358.15 only, contracts issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(b) (1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars ($10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement contracts shall file annually its prepaid or periodic charges and supporting documentation including ratios of incurred losses to earned prepaid or periodic charges by contract duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which charges are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement contracts shall file with the director, in accordance with applicable filing procedures, all of the following:

(1) (A) Appropriate prepaid or periodic charge adjustments necessary to produce loss ratios as anticipated for the current charge for the applicable contracts. The supporting documents necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make prepaid or periodic charge adjustments necessary to produce an expected loss ratio under the contract to conform to minimum loss ratio standards for Medicare supplement contracts and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current charges by the issuer for the Medicare supplement contracts. No charge adjustment that would modify the loss ratio experience under the contract other than the adjustments described in this section shall be made with respect to a contract at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make prepaid or periodic charge adjustments acceptable to the director, the director may order charge adjustments,

refunds, or credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate contract amendments needed to accomplish the Medicare supplement contract modifications necessary to eliminate benefit duplications with Medicare. The contract amendments shall provide a clear description of the Medicare supplement benefits provided by the contract.

(d) (1) The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a contract form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(2) The director may conduct a public hearing to gather information if the experience of the form filed under paragraph (1) of subdivision (b) for the previous reporting period is not in compliance with the applicable loss ratio standard.

The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

SEC. 11. Section 1358.15 of the Health and Safety Code is amended to read:

1358.15. (a) An issuer shall not advertise, solicit, or issue for delivery a Medicare supplement contract to a resident of this state unless the contract has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. Until January 1, 2001, or 90 days after approval of Medicare supplement contracts submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement contracts.

(b) An issuer shall file any riders or amendments to contract forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only in the state where the contract was issued.

(c) An issuer shall not use or change prepaid or periodic charges for a Medicare supplement contract unless the charges and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(d) (1) Except as provided in paragraph (2), an issuer shall not file for approval more than one contract of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four additional contracts of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

(C) The addition of either guaranteed issue or underwritten coverage.

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual contract, a group contract, an individual Medicare Select contract, or a group Medicare Select contract.

(e) (1) Except as provided in subdivision (a), an issuer shall continue to make available for purchase any contract issued after January 1, 2001, that has been approved by the director. A contract shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(A) An issuer may discontinue the availability of a contract if the issuer provides to the director in writing its decision at least 30 days prior to discontinuing the availability of the form of the contract. After receipt of the notice by the director, the issuer shall no longer offer for sale the contract in this state.

(B) An issuer that discontinues the availability of a contract pursuant to subparagraph (A) shall not file for approval a new contract of the same type for the same standard Medicare supplement benefit plan as the discontinued contract for a period of five years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential that is in the public interest.

(f) (1) Except as provided in paragraph (2), the experience of all contracts of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 1358.14.

(2) Contracts assumed under an assumption reinsurance agreement shall not be combined with the experience of other contracts for purposes of the refund or credit calculation.

(g) A Medicare supplement contract shall be deemed not to be fair, just, or consistent with the objectives of this chapter at all times, and shall not be advertised, solicited, or issued for delivery at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the director that the provisions of the contract are deemed to be fair, just, and consistent with the objectives of this chapter, and ending with the earlier to occur of the events indicated in subdivision (h).

(h) The period of time indicated in subdivision (g) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the director of the immediate past notification referred to in subdivision (g) specifying the basis for the revocation, (2) the last day of the prepaid or periodic charge calculation period, that in no event may exceed one year, or (3) June 30, of the next succeeding calendar year.

(i) An issuer shall secure the director's review of a contract subject to this article by submitting, not less than 30 days prior to any proposed advertising or other use of the contract not already protected by a currently effective notice under subdivision (g), the following for the director's review:

(1) A copy of the contract.

(2) A copy of the disclosure form.

(3) A representation that the contract complies with the provisions of this chapter and the rules adopted thereunder.

(4) A completed copy of the "Medicare Supplement Health Care Service Plan Contract Experience Exhibit" set forth in Section 1358.145.

(5) A copy of the calculations for the actual or expected loss ratio.

(6) Supporting data used in calculating the actual or expected loss ratio as indicated in Section 1358.14.

(7) An actuarial certification, as specified in Section 1358.14, of the loss ratio computations.

(8) If required by the director, actuarial certification, as specified in Section 1358.14, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the director.

(9) An undertaking by the issuer to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified.

(10) A signed statement of the president of the issuer or other officer of the issuer designated by that person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(j) An issuer that submits information pursuant to subdivision (i) shall provide any additional information as may be requested by the director to enable the director to conclude that the contract complies with the provisions of this chapter and rules adopted thereunder.

(k) For the purposes of this section, the term "decertified," as applied to a contract, means that the director by written notice has found that the contract no longer complies with the provisions of this chapter and the

rules adopted thereunder and has revoked the prior authorization to display on the contract the emblem indicating certification.

(*l*) Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and the amount of prepaid charges may be modified, as indicated in paragraph (6) of subdivision (a) of Section 1300.67.4 of Title 28 of the California Code of Regulations, to correspond with those changes.

SEC. 12 Section 1358.16 of the Health and Safety Code is amended to read:

1358.16. (a) An issuer or other entity may provide a commission or other compensation to a solicitor or other representative for the sale of a Medicare supplement contract only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the contract in the second year or period.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than five renewal years.

(c) No issuer shall provide compensation to a solicitor or solicitor firm, and no solicitor or solicitor firm shall receive compensation, greater than the renewal compensation payable by the replacing issuer on renewal contracts if an existing contract is replaced.

(d) For purposes of this section, "commission" or "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the contract, including, but not limited to, bonuses, gifts, prizes, awards, and finders' fees.

SEC. 13. Section 1358.17 of the Health and Safety Code is amended to read:

1358.17. (a) (1) Medicare supplement contracts shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with subdivision (a) of Section 1365 and the rules adopted thereunder. The provision shall be appropriately captioned and shall appear on the first page of the contract, and shall include any reservation by the issuer of the right to change prepaid or periodic charges and any automatic renewal increases based on the enrollee's age.

(2) The contract shall contain the provisions required to be set forth by Section 1300.67.4 of Title 28 of the California Code of Regulations.

(b) (1) Except for contract amendments by which the issuer effectuates a request made in writing by the enrollee, exercises a specifically reserved right under a Medicare supplement contract, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all amendments to a Medicare supplement contract after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the contract shall require a signed acceptance by the subscriber. After the date of contract issue, any amendment that increases benefits or coverage with a concomitant increase in prepaid or periodic

charges during the contract term shall be agreed to in writing signed by the subscriber, unless the benefits are required by the minimum standards for Medicare supplement contracts, or if the increased benefits or coverage is required by law. If a separate additional charge is made for benefits provided in connection with contract amendments, the charge shall be set forth in the contract.

(2) An issuer shall not in any way reduce or eliminate any benefit or coverage under a Medicare supplement contract at any time after the date of entering the contract, including dates of reinstatement or renewal, unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits. The issuer shall not increase benefits or coverage with a concomitant increase in prepaid or periodic charges during the term of the contract unless and until the change is voluntarily agreed to in writing signed by the subscriber or enrollee or unless the increased benefits or coverage is required by law or regulation.

(c) Medicare supplement contracts shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a Medicare supplement contract contains any limitations with respect to preexisting conditions, those limitations shall appear as a separate paragraph of the contract and be labeled as "Preexisting Condition Limitations."

(e) (1) Medicare supplement contracts shall have a notice prominently printed in no less than 10-point uppercase type, on the cover page of the contract or attached thereto stating that the applicant shall have the right to return the contract within 30 days of its receipt via regular mail, and to have any charges refunded in a timely manner if, after examination of the contract, the covered person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f) (1) Issuers of health care service plan contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a guide to health insurance for people with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the contracts are advertised, solicited, or issued for delivery as Medicare supplement contracts as defined in this article. Except in the case of direct

response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the contract is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its enrollees and subscribers of modifications it has made to Medicare supplement contracts in a format acceptable to the director. The notice shall include both of the following:

(1) A description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement contract.

(2) Inform each enrollee as to when any adjustment in prepaid or periodic charges is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any adjustments of prepaid or periodic charges shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(i) The notices shall not contain or be accompanied by any solicitation.

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the contract shall accompany the contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, information about prepaid or periodic charges, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All benefit plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Information about prepaid or periodic charges for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The charge and mode shall be stated for all plans that are offered to the prospective applicant. All possible charges for the prospective applicant shall be illustrated.

(3) The disclosure pages shall be in the language and format described below in no less than 12-point type.

INFORMATION ABOUT PREPAID OR PERIODIC CHARGES

[Insert plan's name] can only raise your charges if it raises the charge for all contracts like yours in this state. [If the charge is based on the increasing age of the enrollee, include information specifying when charges will change.]

DISCLOSURES

Use this outline to compare benefits and charges among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing the most important features of your Medicare supplement plan contract. This is not the plan contract and only the actual contract provisions will control. You must read the contract itself to understand all of the rights and duties of both you and [insert the health care service plan's name].

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your contract, you may return it to [insert plan's address]. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing other health coverage, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts displaying the features of each benefit plan offered by the issuer shall use the uniform format and language shown in the charts set forth in Section 17 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as most recently adopted by the National Association of Insurance Commissioners. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. An issuer may use additional benefit plan designations on these charts.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

(k) Notwithstanding Section 1300.63.2 of Title 28 of the California Code of Regulations, no issuer shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(*l*) The director may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(m) (1) Any health care service plan contract, other than a Medicare supplement contract, a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other contract identified in subdivision (b) of Section 1358.3, issued for delivery in this state to persons eligible for Medicare, shall notify enrollees under the contract that the contract is not a Medicare supplement contract. The notice shall either be printed or attached to the first page of the outline of coverage delivered to enrollees under the contract, or if no outline of coverage is delivered, to the first page of the contract delivered to enrollees. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance contracts described in paragraph (1) shall disclose the extent to which the contract duplicates Medicare in a manner required by the director. The disclosure statement shall be provided as a part of, or together with, the application for the contract.

(n) A Medicare supplement contract that does not cover custodial care shall, on the cover page of the outline of coverages, contain the following statement in uppercase type: "THIS POLICY DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY."

(o) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

SEC. 14. Section 1358.18 of the Health and Safety Code is amended to read:

1358.18. In the interest of full and fair disclosure, and to assure the availability of necessary consumer information to potential subscribers or enrollees not possessing a special knowledge of Medicare, health care service plans, or Medicare supplement contracts, an issuer shall comply with the following provisions:

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate or plan contract in force or whether a Medicare supplement contract is intended to replace any other disability policy or certificate, or plan contract, presently in force. A supplementary application or other form to be signed by the applicant and solicitor containing those questions and statements may be used.

"(Statements)

(1) You do not need more than one Medicare supplement policy or contract.

(2) If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement contract.

(4) If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you

enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement contract by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal or Medicaid Program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance contract or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through California's Medi-Cal program?

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement contract?

Yes____ No____

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement contract to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare supplement policy or certificate or contract in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

Yes____ No____

(c) If so, do you intend to replace your current Medicare supplement policy or certificate or contract with this contract?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what companies and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank).

(b) Solicitors shall list any other health insurance policies or plan contracts they have sold to the applicant as follows:

(1) List policies and contracts sold that are still in force.

(2) List policies and contracts sold in the past five years that are no longer in force.

(c) An issuer issuing Medicare supplement contracts without a solicitor or solicitor firm (a direct response issuer) shall return to the applicant, upon delivery of the contract, a copy of the application or supplemental forms, signed by the applicant and acknowledged by the issuer.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement contract, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the contract the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be provided in substantially the following form in no less than 10-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

(Company name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate an existing Medicare supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by [Plan Name]. Your contract to be issued by [Plan Name] will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or contract only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY PLAN, SOLICITOR, SOLICITOR FIRM, OR OTHER REPRESENTATIVE:

(1) I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement contract is being purchased for the following reason (check one):

__ Additional benefits.

__No change in benefits, but lower premiums or charges.
__Fewer benefits and lower premiums or charges.
__Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.
__Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:
__Other. (please specify) _____

(2) You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(5) Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

_____
(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

_____
(Applicant's Signature)

_____
(Date)

(f) The application form or other consumer information for persons eligible for Medicare and used by an issuer shall contain as an attachment a Medicare supplement buyer's guide in the form approved by the director. The application or other consumer information, containing as an attachment the buyer's guide, shall be mailed or delivered to each applicant applying for that coverage at or before the time of application and, to establish compliance with this subdivision, the issuer shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. No issuer shall make use of or otherwise disseminate any buyer's guide that does not accurately outline current Medicare

supplement benefits. No issuer shall be required to provide more than one copy of the buyer's guide to any applicant.

(g) An issuer may comply with the requirement of this section in the case of group contracts by causing the subscriber (1) to disseminate copies of the disclosure form containing as an attachment the buyer's guide to all persons eligible under the group contract at the time those persons are offered the Medicare supplement plan, and (2) collecting and forwarding to the issuer an acknowledgment of receipt of the disclosure form containing as an attachment the buyer's guide from each enrollee.

(h) Commencing January 1, 2007, an issuer shall not require or request health information from an applicant who is guaranteed issuance of any Medicare supplement coverage or require or request the applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996 during a period of guaranteed issuance of any Medicare supplement coverage and shall inform the applicant of periods of guaranteed issuance of Medicare supplement coverage. A supplementary application or other form containing those statements that the applicant and solicitor are required to sign may be used for this purpose. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

SEC. 15. Section 1358.20 of the Health and Safety Code is amended to read:

1358.20. (a) An issuer, directly or through solicitors or other representatives, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of Medicare supplement coverage by its solicitors or other representatives will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive coverage is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and contract, the following:

"Notice to buyer: This Medicare supplement contract may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement contract already has health care coverage and the types and amounts of that coverage.

(5) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

(1) Twisting, which means knowingly making any misleading representation or incomplete or fraudulent comparison of any coverages or issuers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any coverage or to take out coverage with another plan or insurer.

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of coverage through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of coverage.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of coverage and that contact will be made by a health care service plan or its representative.

(c) The terms "Medicare supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the contract is issued in compliance with this article.

SEC. 16. Section 1358.21 of the Health and Safety Code is amended to read:

1358.21. (a) In recommending the purchase or replacement of any Medicare supplement coverage, an issuer or its representative shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement contract that will provide an individual more than one Medicare supplement policy or certificate, or contract, is prohibited.

(c) An issuer shall not issue a Medicare supplement contract to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's coverage under Medicare Part C.

SEC. 17. Section 10192.4 of the Insurance Code is amended to read:

10192.4. The following definitions apply for the purposes of this article:

(a) "Applicant" means:

(1) The person who seeks to contract for insurance benefits, in the case of an individual Medicare supplement policy.

(2) The proposed certificate holder, in the case of a group Medicare supplement policy.

(b) "Bankruptcy" means that situation in which a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(c) "Certificate" means a certificate issued for delivery in this state under a group Medicare supplement policy.

(d) "Certificate form" means the form on which the certificate is issued for delivery by the issuer.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(A) Any individual or group contract, policy, certificate, or program that is written or administered by a health care service plan, health insurer, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage.

(B) Part A or B of Title XVIII of the federal Social Security Act (Medicare).

(C) Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of that act.

(D) Chapter 55 of Title 10 of the United States Code (CHAMPUS).

(E) A medical care program of the Indian Health Service or of a tribal organization.

(F) A state health benefits risk pool.

(G) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program).

(H) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(I) A health benefit plan under Section 5(e) of the federal Peace Corps Act (Section 2504(e) of Title 22 of the United States Code).

(J) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(K) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(g) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(h) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(i) "Issuer" includes insurance companies, fraternal benefit societies, and any other entity delivering, or issuing for delivery, Medicare supplement policies or certificates in this state, except entities subject to Article 3.5 (commencing with Section 1358) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(j) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(k) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(*l*) "Medicare supplement policy" means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395mm) or an issued policy under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.

(m) "Policy form" means the form on which the policy is issued for delivery by the issuer.

(n) "Secretary" means the Secretary of the United States Department of Health and Human Services.

SEC. 18. Section 10192.5 of the Insurance Code is amended to read:

10192.5. A policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

(a) (1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or other similar words of description or characterization.

(2) The definition shall not be more restrictive than the following: "injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(3) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability, or similar law, unless prohibited by law.

(b) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare Program.

(c) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare Program.

(d) (1) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(2) "Health care expenses" shall not include any of the following:

(A) Home office and overhead costs.

(B) Advertising costs.

(C) Commissions and other acquisition costs.

(D) Taxes.
(E) Capital costs.
(F) Administrative costs.
(G) Claims processing costs.

(e) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

(f) "Medicare" shall be defined in the policy and certificate. "Medicare" may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended," or "Title I, Part I of Public Law 89-97, as enacted by the 89th Congress and popularly known as the Health Insurance for the Aged Act, as amended," or words of similar import.

(g) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(h) "Physician" shall not be defined more restrictively than as defined in the Medicare Program.

(i) (1) "Sickness" shall not be defined more restrictively than as follows: "sickness means illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force."

(2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

SEC. 19. Section 10192.6 of the Insurance Code is amended to read:

10192.6. (a) Except for permitted preexisting condition clauses as described in Sections 10192.7 and 10192.8, a policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 10192.8, a Medicare supplement policy with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current policyholders, at the option of the policyholder, who do not enroll in Medicare Part D.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement policy with benefits for outpatient prescription drugs shall not be renewed after the

policyholder enrolls in Medicare Part D unless both of the following conditions exist:

(A) The policy is modified to eliminate outpatient prescription drug coverage for outpatient prescription drug expenses incurred after the effective date of the individual's coverage under a Medicare Part D plan.

(B) The premium is adjusted to reflect the elimination of outpatient prescription drug coverage at the time of enrollment in Medicare Part D, accounting for any claims paid if applicable.

SEC. 20. Section 10192.8 of the Insurance Code is amended to read:

10192.8. The following standards are applicable to all Medicare supplement policies or certificates advertised, solicited, or issued for delivery on or after January 1, 2001. A policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(a) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this article:

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with those changes.

(4) A Medicare supplement policy or certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable or noncancelable.

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or misrepresentation which is shown by the issuer to be material to the acceptance for coverage. The contestability period for Medicare supplement insurance shall be two years.

(C) If the Medicare supplement policy is terminated by the master policyholder and is not replaced as provided under subparagraph (E), the

issuer shall offer certificate holders an individual Medicare supplement policy that, at the option of the certificate holder, either provides for continuation of the benefits contained in the group policy or provides for benefits that otherwise meet the requirements of one of the standardized policies defined in this article.

(D) If an individual is a certificate holder in a group Medicare supplement policy and membership in the group is terminated, the issuer shall either offer the certificate holder the conversion opportunity described in subparagraph (C) or, at the option of the group policyholder, shall offer the certificate holder continuation of coverage under the group policy.

(E) (i) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate that has been in force for six months or more, the replacing issuer shall not impose an exclusion or limitation based on a preexisting condition. If the original coverage has been in force for less than six months, the replacing issuer shall waive any time period applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate to the extent the time was spent under the original coverage.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), the policy as modified as a result of that act shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) (A) (i) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to Medi-Cal or Medicaid under Title XIX of the federal Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to

assistance. Upon receipt of timely notice, the insurer shall return directly to the insured that portion of the premium attributable to the period of Medi-Cal or Medicaid eligibility, subject to adjustment for paid claims. If suspension occurs and if the policyholder or certificate holder loses entitlement to Medi-Cal or Medicaid, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement, or equivalent coverage shall be provided if the prior form is no longer available.

(ii) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for any period that may be provided by federal regulation if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and the policyholder or certificate holder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage if the policyholder provides notice within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for a Medicare Part D enrollee shall not include coverage for outpatient prescription drugs but shall otherwise provide coverage that is substantially equivalent to the coverage in effect before the date of suspension.

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(8) No Medicare supplement policy may limit coverage exclusively to a single disease or affliction.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. However, the benefits described in paragraphs (6) and (7) shall not be offered so long as California is required to disallow these benefits for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the

federal government under Section 1395ss of Title 42 of the United States Code.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of the actual cost, up to the legally billed amount, of an annual mammogram as provided in Section 10123.81, to the extent not paid by Medicare.

(7) Coverage of the actual cost, up to the legally billed amount, of an annual cervical cancer screening test as provided in Section 10123.18, to the extent not paid by Medicare.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 10192.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(3) With respect to the Medicare Part B deductible, coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) With respect to 80 percent of the Medicare Part B excess charges, coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge. If the insurer limits payment to a limiting charge, the insurer has the burden to establish that amount as the legal limit.

(5) With respect to 100 percent of the Medicare Part B excess charges, coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge. If the insurer limits payment to a limiting charge, the insurer has the burden to establish that amount as the legal limit.

(6) With respect to the basic outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement policy may be sold or issued if it includes a prescription drug benefit.

(7) With respect to the extended outpatient prescription drug benefit, coverage for 50 percent of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. On and after January 1, 2006, no Medicare supplement policy may be sold or issued if it includes a prescription drug benefit.

(8) With respect to medically necessary emergency care in a foreign country, coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) With respect to the following, reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, up to a maximum of one hundred twenty dollars ($120) annually under this benefit, however, this benefit shall not include payment for any procedure covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) and patient education to address preventive health care measures.

(B) The following screening tests or preventive services that are not covered by Medicare, the selection and frequency of which are determined to be medically appropriate by the attending physician:

(i) Fecal occult blood test.

(ii) Mammogram.

(C) Influenza vaccine administered at any appropriate time during the year.

(10) With respect to the at-home recovery benefit, coverage for the actual charges up to forty dollars ($40) per visit and an annual maximum of one thousand six hundred dollars ($1,600) per year to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(A) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, or a personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without any limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

(ii) The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

(III) One thousand six hundred dollars ($1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

(i) Home care visits paid for by Medicare or other government programs.

(ii) Care provided by family members, unpaid volunteers, or providers who are not care providers.

(d) The standardized Medicare supplement benefit plan "K" shall consist of the following benefits:

(1) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each day used from the 61st to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of 100 percent of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st to the 150th day, inclusive, in any Medicare benefit period.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment for this benefit as payment in full and shall not bill the insured for any balance.

(4) With respect to the Medicare Part A deductible, coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (10) is met.

(5) With respect to skilled nursing facility care, coverage for 50 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (10) is met.

(6) With respect to hospice care, coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (10) is met.

(7) Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (10) is met.

(8) Except for coverage provided in paragraph (9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible, until the out-of-pocket limitation is met as described in paragraph (10).

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services, after the policyholder pays the Medicare Part B deductible.

(10) Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(e) The standardized Medicare supplement benefit plan "L" shall consist of the following benefits:

(1) The benefits described in paragraphs (1), (2), (3), and (9) of subdivision (d).

(2) With respect to the Medicare Part A deductible, coverage for 75 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation described in paragraph (8) is met.

(3) With respect to skilled nursing facility care, coverage for 75 percent of the coinsurance amount for each day used from the 21st day to the 100th day, inclusive, in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation described in paragraph (8) is met.

(4) With respect to hospice care, coverage for 75 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation described in paragraph (8) is met.

(5) Coverage for 75 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations, until the out-of-pocket limitation described in paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars ($2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) An issuer shall prominently indicate through text edits, or by other means acceptable to the commissioner, an amendment made to a Medicare supplement policy form that the department previously approved on the basis that the amendment is consistent with this section. The department may, in its discretion, restrict its review to amendments made to Medicare supplement policy forms that have not previously been found consistent

with this section in order to facilitate the availability of amended policy forms that are consistent with the federal Medicare Modernization Act. The department shall not restrict its review if the amendment makes additional changes to the Medicare supplement policy form.

SEC. 21. Section 10192.9 of the Insurance Code is amended to read:

10192.9. (a) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subdivision (b) of Section 10192.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by subdivision (f) and by Section 10192.10.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to J, inclusive, listed in subdivision (e), and shall conform to the definitions in Section 10192.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b), (c), (d), and (e) of Section 10192.8 and list the benefits in the order listed in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subdivision (c), other designations to the extent permitted by law.

(e) With respect to the makeup of benefit plans, the following shall apply:

(1) Standardized Medicare supplement benefit plan A shall be limited to the basic (core) benefit common to all benefit plans, as defined in subdivision (b) of Section 10192.8.

(2) Standardized Medicare supplement benefit plan B shall include only the following: the core benefit, plus the Medicare Part A deductible as defined in paragraph (1) of subdivision (c) of Section 10192.8.

(3) Standardized Medicare supplement benefit plan C shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), and (8) of subdivision (c) of Section 10192.8, respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (8), and (10) of subdivision (c) of Section 10192.8, respectively.

(5) Standardized Medicare supplement benefit plan E shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs (1), (2), (8), and (9) of subdivision (c) of Section 10192.8, respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: the core benefit, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(8) Standardized Medicare supplement benefit plan G shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (4), (8), and (10) of Section 10192.8, respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (6), and (8) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: the core benefit, plus the Medicare Part A deductible,

skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8, respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be one thousand five hundred dollars ($1,500) for 1998 and 1999, and shall be based on a calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold on or after January 1, 2006.

(13) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in subdivision (d) of Section 10192.8.

(14) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in subdivision (e) of Section 10192.8.

(f) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, that are not otherwise available and that are cost-effective and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. On and after January 1, 2006, the innovative benefit shall not include an outpatient prescription drug benefit.

SEC. 22. Section 10192.10 of the Insurance Code is amended to read:

10192.10. (a) (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) A policy or certificate shall not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) For the purposes of this section:

(1) "Appeal" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(2) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, seeking to offer, advertising, marketing, soliciting, or issuing a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer or other entity to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

(8) "Grievance" means a written complaint registered by an individual for resolution under the formal grievance procedure, which may involve, but is not limited to, the administration, claims practices, or provision of services by the issuer or its network providers.

(9) "Medicare Select coverage" means Medicare supplement coverage through a preferred provider organization or any other type of restricted network, which coverage has been approved by the commissioner under this section.

(10) "Preferred provider organization" means a health care provider or an entity contracting with health care providers that (A) establishes alternative or discounted rates of payment, (B) offers the insureds certain advantages for selecting the member providers, or (C) withholds from the insureds certain advantages if they choose providers other than the member providers. Organizations regulated as Medicare Select include, but are not limited to, provider groups, hospital marketing plans, and organizations that are formed or operated by insurers or third-party administrators.

(c) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate pursuant to this section if the commissioner finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(e) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

(A) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and afterhour care. The hours of operation and availability of afterhour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) That the number of network providers in the service area is sufficient, with respect to current and expected policyholders, as to either of the following:

(i) To deliver adequately all services that are subject to a restricted network provision.

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 24 hours per day and seven days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, that there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate.

This subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the appeal or grievance procedure to be utilized.

(4) A description of the quality assurance program, including all of the following:

(A) The formal organizational structure.

(B) The written criteria for selection, retention, and removal of network providers.

(C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with subdivision (i).

(7) Any other information requested by the commissioner.

(f) (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed at the commissioner's request, but at least quarterly.

(g) A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition.

(2) It is not reasonable to obtain services through a network provider.

(h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with both of the following:

(A) Other Medicare supplement policies or certificates offered by the issuer.

(B) Other Medicare Select policies or certificates.

(2) A description, including address, telephone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. The description shall inform the applicant that expenses incurred when using out-of-network providers are excluded from the out-of-pocket annual limit in benefit plans K and L, unless the policy or certificate provides otherwise.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's or certificate holder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance, grievance, and appeal procedure.

(j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subdivision (i) and that the applicant understands the restrictions of the Medicare Select policy or certificate. Acknowledgments shall be maintained by the insurer for at least five years in accordance with Section 10508.

(k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written appeals and grievances from the

insureds. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The appeal and grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder or certificate holder describing how an appeal or grievance may be registered with the issuer.

(3) Appeals or grievances shall be considered in a timely manner and shall be transmitted to appropriate fiduciaries who have authority to fully investigate the issue and take corrective action.

(4) If an appeal or grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of an appeal or grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its appeal or grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of appeals or grievances filed in the past year and a summary of the subject, nature, and resolution of those appeals or grievances.

(7) Detailed information describing in writing how to register an appeal or grievance shall be provided to the insured prior to, or simultaneously with, the issuance of the policy or certificate.

(8) The issuer shall maintain records of each appeal or grievance for at least five years.

(*l*) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(m) (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months, unless the replacement policy or certificate includes at-home recovery benefits that were not included in the Medicare Select coverage.

(2) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the commissioner determines that

Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subdivision, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Medicare Part B excess charges.

(o) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services for the purpose of evaluating the Medicare Select program.

(p) The commissioner may grant special Medicare Select status to plans of guaranteed renewable Medicare supplement coverage provided through a preferred provider organization, which plans were offered to the public or in force before the effective date of this section, if the commissioner determines that the applicants will receive benefits and consumer protections that are substantially equivalent to those in other Medicare Select plans identified in this section, and if the issuer satisfies the following requirements:

(1) The issuer shall apply within one year of the effective date of this section by submitting to the commissioner the following items:

(A) The current plan of operation as defined in subdivision (e).

(B) If the written disclosures of subdivision (i) have not been delivered to each applicant as required, the issuer's plan to accomplish full disclosure to every insured and to achieve substantial compliance with subdivision (j).

(C) The issuer's statement of intent to comply with subdivision (f).

(D) If the plan of operation does not comply with the standards of subdivision (g), (h), (k), (*l*), or (m), the issuer's plan for achieving substantial compliance with these subdivisions for every insured.

(2) The issuer shall alter the plan as requested by the commissioner in order to bring the plan into substantial compliance with Medicare Select standards.

(3) The issuer shall issue disclosures or other notices to its insureds regarding its status as Medicare Select as ordered by the commissioner.

(4) The issuer shall provide data as provided in subdivision (o).

SEC. 23. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(2) An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants, Medicare supplement benefit plan H, I, or J, if currently available, and commencing January 1, 2007, shall make available to them Medicare supplement benefit plan K or L, if currently available. The selection among Medicare supplement plan H, I, or J and the selection between Medicare supplement benefit plan K or L shall be made at the issuer's discretion.

(3) This section and Section 10192.12 do not prohibit an issuer in determining premium rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification. This section shall not be construed as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10192.8.

(b) (1) If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the commissioner.

(c) Except as provided in subdivision (b) and Section 10192.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(d) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of his or her enrollment in Medicare Part B, or if notified retroactively of his or her eligibility for Medicare, for six months following notice of eligibility. Every issuer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that issuer at the time of application. Issuers shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

(e) (1) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(A) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(B) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(C) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(2) For purposes of this subdivision, "employer-sponsored retiree health plan" includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(f) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(g) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health

care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. An issuer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(i) Commencing January 1, 2007, an individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program because of an increase in the individual's income or assets.

SEC. 24. Section 10192.12 of the Insurance Code is repealed.

SEC. 25. Section 10192.12 is added to the Insurance Code, to read:

10192.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement policy, eligible persons are those individuals described in subdivision (b) who seek to enroll under the policy during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

(A) Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subdivision (e) that is offered and is available for issuance to new enrollees by the issuer.

(B) Discriminate in the pricing of that Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition.

(C) Impose an exclusion of benefits based on a preexisting condition under that Medicare supplement policy.

(b) An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement policy issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(F) The individual meets other exceptional conditions as the secretary may provide.

(3) The individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and circumstances similar to those described in paragraph (2) exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) The individual meets both of the following conditions:

(A) The individual is enrolled with any of the following:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) The individual is enrolled under a Medicare supplement policy, and the enrollment ceases because of any of the following circumstances:

(A) The insolvency of the issuer or bankruptcy of the nonissuer organization, or other involuntary termination of coverage or enrollment under the policy.

(B) The issuer of the policy substantially violated a material provision of the policy.

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(7) The individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) The individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (4) of subdivision (e).

(c) (1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminates:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(3) In the case of an individual described in subparagraph (A) of paragraph (5) of subdivision (b), the guaranteed issue period begins on the

earlier of the following two dates and ends on the date that is 63 days after the date the coverage is terminated:

(A) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any.

(B) The date that the applicable coverage is terminated.

(4) In the case of an individual described in paragraph (2), (3), (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of, subdivision (b) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of the disenrollment.

(5) In the case of an individual described in paragraph (8) of subdivision (b), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial enrollment period for Medicare Part D and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a

benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement policy in which he or she was most recently enrolled, if available from the same issuer. If that policy is not available, the eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, is entitled to a Medicare supplement policy that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement policy offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L and that is offered and is available for issuance to a new enrollee by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) (1) At the time of an event described in subdivision (b) by which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subdivision (b) by which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subdivision (a). The notice shall be communicated within 10 working days of the date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an insured paid in advance and shall terminate coverage upon the request of an insured.

SEC. 26. Section 10192.14 of the Insurance Code is amended to read:

10192.14. (a) (1) (A) With respect to loss ratio standards, a Medicare supplement policy form or certificate form shall not be advertised, solicited, or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are

computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form at least 75 percent of the aggregate amount of premiums earned in the case of group policies, or at least 65 percent of the aggregate amount of premiums earned in the case of individual policies.

(B) Loss ratio standards shall be calculated on the basis of incurred claims experience, and earned premiums shall be calculated for the period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision (d) of Section 10192.15 only, policies issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

(b) (1) With respect to refund or credit calculations, an issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form required by the commissioner for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to policies or certificates advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and this code. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates shall file with the commissioner, in accordance with applicable filing procedures, all of the following:

(1) (A) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described in this section shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

SEC. 27. Section 10192.15 of the Insurance Code is amended to read:

10192.15. (a) An issuer shall not advertise, solicit, or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner. Master policies issued outside California shall be filed for informational purposes along with the certificates. Until January 1, 2001, or 90 days after approval of Medicare supplement policies or certificates submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement policies or certificates.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only with the commissioner in the state where the policy or certificate was issued.

(c) (1) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(2) Paragraph (1) of subdivision (b) of Section 10290 shall not apply to Medicare supplement insurance forms or rates. However, the commissioner may authorize in writing, for good cause only, the limited use of a form or rates after that form or the rates have been filed with the commissioner for 60 days and have not otherwise been acted upon.

(d) (1) Except as provided in paragraph (2), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

(C) The addition of either guaranteed issue or underwritten coverage.

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(e) (1) Except as provided in subdivision (a), an issuer shall continue to make available for purchase any policy form or certificate form issued after January 1, 2001, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(A) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 60 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(B) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph (A) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subdivision.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. The commissioner may approve the change if it is in the public interest.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest. The commissioner may approve a change to the differential if it is in the public interest.

(f) (1) Except as provided in paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 10192.14.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

SEC. 28. Section 10192.17 of the Insurance Code is amended to read:

10192.17. (a) Medicare supplement policies and certificates shall include a renewal, continuation, or conversion provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder’s age.

(b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved

right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or upon reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, those limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(e) (1) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, and of the outline of coverage, or attached thereto, in no less than 10-point uppercase type, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate, via regular mail, within 30 days of receiving it, and to have the full premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f) (1) Issuers of health insurance policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct

response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

(2) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement policies or certificates in a format acceptable to the commissioner. The notice shall include both of the following:

(1) A description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(h) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(i) The notices shall not contain or be accompanied by any solicitation.

(j) (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(2) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(3) The commissioner may adopt regulations to implement this article, including, but not limited to, regulations that specify the required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(k) (1) Any disability insurance policy or certificate, a basic, catastrophic or major medical expense policy, or single premium nonrenewal policy or certificate issued to persons eligible for Medicare, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other policy identified in subdivision (b) of Section 10192.3, advertised, solicited, or issued for delivery in this state to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the disability insurance policies or certificates described in paragraph (1) shall disclose the extent to which the policy duplicates Medicare in a manner required by the commissioner. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

(*l*) (1) Insurers issuing Medicare supplement policies or certificates for delivery in California shall provide an outline of coverage to all applicants at the time of presentation for examination or sale as provided in Section 10605, and in no case later than at the time the application is made. Except for direct response policies, insurers shall obtain a written acknowledgment of receipt of the outline from the applicant.

Any advertisement that is not a presentation for examination or sale as defined in subdivision (e) of Section 10601 shall contain a notice in no less than 10-point uppercase type that an outline of coverage is available upon request. The insurer or agent that receives any request for an outline of coverage shall provide an outline of coverage to the person making the request within 14 days of receipt of the request.

(2) If an outline of coverage is provided at or before the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the

policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage shall be in the language and format prescribed in this subdivision in no less than 12-point type, and shall include the following items in the order prescribed below. Titles, as set forth below in paragraphs (B) to (H), inclusive, shall be capitalized, centered, and printed in boldface type. The outline of coverage shall include the items, and in the same order, specified in the chart set forth in Section 17 of the Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as adopted by the National Association of Insurance Commissioners in 2004.

(A) The cover page shall contain the 12-plan (A-L) charts. The plans offered by the insurer shall be clearly identified. Innovative benefits shall be explained in a manner approved by the commissioner. The text shall read:

"Medicare supplement insurance can be sold in only 12 standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan A. Some plans may not be available.

The BASIC BENEFITS included in ALL plans are:

Hospitalization: Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Medicare Part B coinsurance (usually 20 percent of the Medicare-approved amount).

Blood: First three pints of blood each year.

Mammogram: One annual screening to the extent not covered by Medicare.

Cervical cancer test: One annual screening."

[Reference to the mammogram and cervical cancer test shall not be included so long as California is required to disallow them for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other agent of the federal government under 42 U.S.C. Sec. 1395ss.]

(B) PREMIUM INFORMATION. Premium information for plans that are offered by the insurer shall be shown on, or immediately following, the cover page and shall be clearly and prominently displayed. The premium and mode shall be stated for all offered plans. All possible premiums for the prospective applicant shall be illustrated in writing. If the premium is based on the increasing age of the insured, information specifying when and how premiums will change shall be clearly illustrated in writing. The text shall state: "We [the insurer's name] can only raise your premium if we raise the premium for all policies like yours in California."

(C) The text shall state: "Use this outline to compare benefits and premiums among policies."

(D) READ YOUR POLICY VERY CAREFULLY. The text shall state: "This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company."

(E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The text shall state: "If you find that you are not satisfied with your policy, you may return it to [insert the insurer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it has never been issued and return all of your payments."

(F) POLICY REPLACEMENT. The text shall read: "If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it."

(G) DISCLOSURES. The text shall read: "This policy may not fully cover all of your medical costs." "Neither this company nor any of its agents are connected with Medicare." "This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult 'The Medicare Handbook' for more details." "For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California."

The disclosure required by this paragraph, as revised by amendments made during the 1996 portion of the 1995-96 Regular Session, shall be included in the required disclosure form no later than January 1, 1998.

(H) [For policies that are not guaranteed issue] COMPLETE ANSWERS ARE IMPORTANT. The text shall read: "When you fill out the application for a new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may have the right to cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded."

(I) One chart for each benefit plan offered by the insurer showing the services, Medicare payments, payments under the policy and payments expected from the insured, using the same uniform format and language. No more than four plans may be shown on one page. Include an explanation of any innovative benefits in a manner approved by the commissioner.

(m) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

SEC. 29. Section 10192.18 of the Insurance Code is amended to read:

10192.18. (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing those questions and statements may be used.

"(Statements)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.

(4) If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and

concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through California's Medi-Cal program?

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

Yes____ No____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what companies and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(b) Agents shall list any other health insurance policies they have sold to the applicant as follows:

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance

Commissioners for this purpose. The replacement notice shall be printed in no less than 10-point type in substantially the following form:

[Insurer's name and address]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

__ Additional benefits that are: _____

__ No change in benefits, but lower premiums.

__ Fewer benefits and lower premiums.

__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:

__ Other reasons specified here: _____

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____
(Signature of Agent, Broker, or Other Representative)

_____
(Signature of Applicant)

_____
(Date)

(f) No issuer, broker, agent, or other person shall cause an insured to replace a Medicare supplement insurance policy unnecessarily. In recommending replacement of any Medicare supplement insurance, an agent shall make reasonable efforts to determine the appropriateness to the potential insured.

(g) Commencing January 1, 2007, an issuer shall not require or request health information from an applicant who is guaranteed issuance of any Medicare supplement coverage or require or request the applicant to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information or to sign a form required by the federal Health Insurance Portability and Accountability Act of 1996 during a period of guaranteed issuance of any Medicare supplement coverage and shall inform the applicant of periods of guaranteed insurance of Medicare supplement coverage. A supplementary application or other form containing those statements that the applicant and solicitor are required to sign may be used for this purpose. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

SEC. 30. Section 10192.20 of the Insurance Code is amended to read:

10192.20. (a) An issuer, directly or through its producers, shall do each of the following:

(1) Establish marketing procedures to ensure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to ensure that excessive insurance is not sold or issued.

(3) Display prominently by type, stamp, or other appropriate means, on the first page of the policy, the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for a Medicare supplement policy already has health insurance and the types and amounts of that insurance.

(5) Establish auditable procedures for verifying compliance with this subdivision.

(b) In addition to the practices prohibited by this code or any other law, the following acts and practices are prohibited:

(1) Twisting, which means knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics, which means employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising, which means making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is the solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(c) The terms "Medicare supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this article.

(d) The commissioner each year shall prepare a rate guide for Medicare supplement insurance and Medicare supplement contracts. The commissioner each year shall make the rate guide available on or before the date of the fall Medicare annual open enrollment. The rate guide shall include all of the following for each company that sells Medicare supplemental insurance or Medicare supplement contracts in California:

(1) A listing of all the policies, plans A to L, inclusive, that are available from the company.

(2) A listing of all the policies, plans A to L, inclusive, for Medicare beneficiaries under the age of 65 that are available from the company.

(3) The toll-free telephone number of the company that consumers can use to obtain information from the company.

(4) Sample rates for each policy listed pursuant to paragraphs (1) and (2). The sample rates shall be for ages 0-65, 65, 70, 75, and 80.

(5) The premium rate methodology for each policy listed pursuant to paragraphs (1) and (2). "Premium rate methodology" means attained age, issue age, or community rated.

(6) The waiting period for preexisting conditions for each policy listed pursuant to paragraphs (1) and (2).

(e) The consumer rate guide prepared pursuant to subdivision (d) shall be distributed using all of the following methods:

(1) Through Health Insurance Counseling and Advocacy Program (HICAP) offices.

(2) By telephone, using the department's consumer toll-free telephone number.

(3) On the department's Internet Web site.

(4) In addition to the distribution methods described in paragraphs (1) to (3), inclusive, each insurer that markets Medicare supplement insurance or Medicare supplement contracts in this state shall provide on the

application form a statement that reads as follows: "A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov)."

SEC. 31. Section 10192.21 of the Insurance Code is amended to read:

10192.21. (a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(c) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's coverage under Medicare Part C.

SEC. 32. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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